Agency A, Inc.

Position Description

REGISTERED NURSE

I. Job Summary: Under the supervision of the Clinic or Day Center Manager, is responsible for assessing, coordinating, monitoring, and providing clinical treatment and services required by participants of the Agency A sites and/or in their homes.

II. Duties and Responsibilities:

- Conducts initial history, physical exam and functional nursing assessments of potential participants.
- Facilitates the integration of new participants into the Agency A health care delivery system including medication, immunizations, routine monitoring of chronic problems through the kardex system and nursing care plan development.
- Functions as a member of the interdisciplinary team. Assists in development of participants' plan of care. Provides updates to team regarding participant's change in health or functional status.
- Provides ongoing nursing assessments on a scheduled basis and submits PACE data requirements.
- Monitors and delivers routine nursing care; updates kardexes and nursing care plans on a regular basis. Oversees cares and interventions delegated to LPNs, MAs, Nursing Secretaries and PCWs.
- Provides liaison with primary care provider in the event of an episodic illness; assists in coordinating services provided by primary care provider and provides education to participant and caregivers as needed.
- Administers and monitors participants' medications prescribed by the primary care provider. Oversees medication passing by LPN or trained PCW.
- Assists participants in maintaining optimum health; provides health education and counseling to participants and caregivers facing chronic conditions and end of life issues.
- Assures that documentation of nursing services provided is timely, legible, accurate and follows AGENCY A protocol.
- As required, participates in care plan development for participants in their home, the hospital, group home or nursing home, and conducts visits as needed to provide services and/or follow-through.
- Assists in obtaining and coordinating services provided by specialists and contracted services.
- Assists with orientation of new clinic staff.
- Provides basic first aid to agency employees as required by incident or injury.
- Participates in participant-related conferences as designated.
- Attends staff meetings and in-services as required.

- Protects privacy and maintains confidentiality of employee, participant and sensitive agency information.
- Provides weekend, holiday and on-call coverage on a rotating basis.
- Performs related duties as assigned.

Duties and Responsibilities Specific to RNs Providing Home Care Services:

- Coordinates all home care services with contracted home care agencies as requested by the interdisciplinary team; acts as liaison with contracted home care agencies.
- Serves as a member of the interdisciplinary team and participates in the assessment, development, monitoring and updating of each participant's nursing care plan and home care needs.
- Provides ongoing direction to Home Care Department PCWs and evaluates their service delivery.
- Provides in-home orientation on use of DME for caregivers and other Home Care Department staff.
- Prepares Home Care Department forms and reports as required, including maintenance of Home Care Record of Services.
- Assists with orientation of new Home Care staff, as needed.

III. Qualifications and Requirements:

Education: Degree/diploma in nursing and current State of Wisconsin Registered Nurse license required. Bachelor Degree in Nursing preferred.

Experience: Minimum one year recent experience in clinical nursing with a frail or elderly population required. Experience in a community-based or long-term care setting involving the elderly preferred.

Skills and Knowledge:

- Excellent clinical skills necessary for the care of older adults with complex, multi-system health problems.
- Working knowledge of physical, mental and social needs of the frail elderly population.
- Ability to problem-solve and plan effectively.
- Effective oral and written communication skills.
- Demonstrated ability to function on an interdisciplinary team.
- Ability to utilize basic computer skills in the workplace.
- Demonstrates necessary skills and knowledge as outlined in attached position-specific Competency Assessment Profile.

Desired Personal Attributes:

- Flexible, resourceful, dependable and self-directed.
- Interest in innovative risk-based long-term care program for the elderly.
- Ability to work sensitively and effectively with individuals of diverse ethnic and cultural backgrounds.

Other:

- Requires physical strength to perform the essential functions of the job.
- Must be able to work required schedule.
- May be required to travel between sites and homes.

POSITION DESCRIPTION

POSTION TITLE:
Registered Nurse

DEPARTMENT:
Partnership

REPORTS TO:
Partnership Program Manager

FLSA STATUS:
Non-Exempt

POSITION SUMMARY:
Under supervision of the Partnership Program Manager, the Registered Nurse is responsible for assessing, planning, intervening/delivering, coordinating, monitoring and evaluating in-home care for participants in collaboration with the care team to enable participants to live as independently as possible in the community. The RN provides a range of services which include: providing participant care; coordinating and monitoring case management in collaboration with interdisciplinary team; delegating and supervising in-home health workers; participating in discharge planning; and related administrative duties. Excellent interpersonal communication, problem solving and conflict resolution skills are essential. The RN must be able to function with a high degree of independence while actively working in collaboration with other team members. The ability to work autonomously and use organizational skills is essential to successfully provide participant services as well as to respond to requests from physicians, other health care disciplines and community professionals.

JOB DUTIES AND RESPONSIBILITIES:

50% Participant Care:

1. Provide in-home physical and functional assessments to identify health issues, functional ability and environmental issues.
2. On-going assessment of functional limitations and safety issues of participants.
3. Develop, document and implement interventions based on health and functional assessments.
4. Collect and record assessment data including the following: physical, environment/safety; response to aging process; functional status; response of illness; health status and goals; etc.
5. Provide direct and indirect nursing care such as specimen collection, wound care, IV therapy, catheter care, oxygen therapy, and other skilled nursing interventions.
6. Provide prevention and health maintenance education to participants at appropriate level and depth, to augment their understanding, in conjunction with NP.
7. Collaborate with family and/or care givers and team to ensure continuity of care.
8. Use interview, observation, physical exam to assess physical/health status, response to illness, medication use and response to the aging process of the participants.

9. In collaboration with NP, assess and manage acute care crisis.
10. Use interview and observation to assess participant/family motivation and mental, cultural, and spiritual status of the participant.
11. In collaboration with the Social Worker, identify informal support systems/networks, coping patterns, problems and strengths for each participant.
12. Coordinate services provided by other skilled agencies.
13. Participate in on-call rotation to assess, triage and manage participant issues. Plan and implement interventions to solve problems with the goals of maintaining independence and preventing further deterioration in health status. Communicate pertinent participant information to physicians, the team and other health care providers, as necessary, in a professional and timely manner.
14. Assess home environment for modification and DME needs. Work with interdisciplinary team to provide DME/DMS.

15% Delegation and Supervision of In-Home Health Workers:

1. Delegate tasks including basic personal care and other tasks appropriately and clearly.
2. In conjunction with MA personal care manager, provide supervision of in-home health workers for those tasks delegated by the RN for each individual participant.
3. Coordinate the scheduling of PCW/CNA services and delegated tasks with MA personal care scheduler.
4. Document delegated activities in a care plan for the PCW to follow and update as needed.
5. Provide education and training to PCW/health care workers as it relates to participants' needs.
6. Evaluate health worker performance periodically giving positive and constructive criticism in a direct and diplomatic manner. Report major or continuing performance problems to MA Personal Care Manager.

10% Case Management:

1. Participate in interdisciplinary team meetings to provide health information and updates regarding participants. Participate as a team member in the development of the individual service plan (ISP); ensure the ISP reflects the participant's life goals to maximize quality of life for that individual.
2. Formulate and update as needed written individualized care plans reflecting in-home care needs for each participant using pertinent and broad-based data including agreed upon participants goals stated as measurable outcomes in collaboration with the team.
3. Participate with team, including participant, in reviewing and evaluating participant outcomes.
4. Provide observations of participants and collaborate with staff so as to prevent and/or minimize acute episodes and emergencies from occurring.
5. Conduct regular participant visits to determine, review and adjust services.

6. Communicate with participant's formal and informal support network as necessary; share information with interdisciplinary team.
7. Provide ongoing support through case management.
8. Be an advocate for participants and assist in obtaining necessary services.
9. In collaboration with the interdisciplinary team, has responsibility for overall participant resource management.

15% Assist in Discharge Planning:

1. Responsible for assisting interdisciplinary team with discharge planning from hospital, nursing home, group home, etc.
2. Assist in coordination of discharge from nursing home to hospital.

10% Administrative Duties:

1. Participate in internal work groups, meetings and committees relative to position responsibilities.
2. Attend appropriate external meetings, groups, organizations and conferences to promote continuity of services and to promote personal professional development.
3. Accurately complete all necessary paperwork--enrollments, health assessments, statistical records, medical records, and other documentation in the required time frames.
4. Participate in ongoing quality improvement activities.
5. Document participant-related activity into the information system as required.

Other:

1. Assist in program development such as: development of an information system; peer support; forums for participants; performance indicators for providers; development of educational materials.
2. Maintain current knowledge base, skills and awareness in community-based and geriatric nursing practice.
3. Attend all required in-service training and meet all required health screening obligations.
4. Participate in forwarding the mission and goals of the Partnership program.
5. Participate in and take responsibility for own learning, seeking feedback on performance and actively participating in self and peer performance appraisal.
6. Provide back up coverage for other nursing personnel as necessary or assigned.
7. Demonstrate respect for participants.
8. Empower each participant to direct her/his own medical/psycho/social care as independently as possible.
9. Maintain participant confidentiality at all times.
10. Practice in a manner congruent with ANA Code Ethics, Wisconsin Nursing Licensure Code, professional Partnership standards.

POSITION QUALIFICATIONS:

- Licensure or eligibility for licensure in the State of Wisconsin as a Registered Nurse required. Bachelor's degree in nursing preferred.
- Experience of over one year as a RN required due to the independent nature of the position. Previous home health experience preferred.
- Geriatric experience greater than six months required. (Sufficient academic experience may be acceptable.)
- Knowledge of the human aging process required.
- Sufficient knowledge base regarding issues of geriatric nursing required.
- Excellent organizational, negotiation, and decision-making skills required.
- Excellent oral and written communication skills required.
- Basic key boarding skills required; ability to enter data into PICS computer system necessary.
- Ability to work well in a team environment. Prefer prior experience as a member of an interdisciplinary team providing nursing care.
- Ability to effectively collaborate with a variety of staff, both internal and external required.
- Ability to function effectively in a fast paced and changing environment with multiple priorities and objectives required.
- Ability to effectively work with team to manage participants' financial resources required.
- Ability to work additional hours as necessary and the ability to participate in an on-call rotation required.
- Effective human relations abilities required:
  - Ability to effect collaborate alliances and promote teamwork.
  - Ability to insure a high level of customer satisfaction.
  - Ability to develop and maintain effective working relationships.
- Ability to present a positive self and organizational image to outside parties required.
- Physical ability to occasionally life 25-75 lbs. and to tolerate repetition and prolonged walking, standing, squatting, bending and twisting. Ability to physically support a participant's weight when assisting with transfers required.
- Commitment to providing excellent customer service required.
- Valid, State of Wisconsin driver's license in good standing (or the ability to obtain) and reliable transportation required.

Position descriptions are not intended to be and should not be construed to be a complete list of all the duties and responsibilities performed by incumbents. Further, they do not represent a complete list of all the performance expectations or the characteristics of individuals required to perform the job adequately. Duties, responsibilities and expectations may be added, deleted, or modified at any time at the discretion of Agency B management.

It is Agency B's policy to base hiring decisions solely on an individual's ability to perform essential job functions. Persons with disabilities are eligible for this position provided they can perform those functions with reasonable accommodation.

I have read and understand that the statements above are a description of the functions assigned my position.

_____

Employee Signature and Date

Agency A, Inc.

Position Description

SOCIAL WORKER

I. **Job Summary**: Under the supervision of the Day Center Manager, Site Administrator, or Social Work Supervisor, provides direct social work case management services to participants in the Agency A Programs; provides direction to Human Services Workers, and oversees and signs off on required case management activities of Human Service Workers.

II. **Duties and Responsibilities:**

- Conducts initial psychosocial assessments on prospective program participants, consults with family or other support system members as needed.
- Develops clear and timely written social service care plans, and implements same for assigned caseload.
- Periodically reviews social service care plans as needed or required, and revises as appropriate.
- Functions as a member of the interdisciplinary team. Maintains regular attendance at, and participation in, interdisciplinary team meetings; collaborates on care planning and service allocation decisions.
- Assists families with problem solving around caregiving issues and serves as the facilitator of family meetings as needed.
- Provides crisis intervention, and advocacy as needed for assigned caseload.
- Provides supportive counseling to participants and families as needed.
- Develops and facilitates support groups.
- In conjunction with the interdisciplinary team, coordinates discharge planning for clients returning home from hospitals, nursing homes or group homes; coordinates admissions to group homes and nursing homes.
- Assists participants with housing issues.
- Maintains current, well-organized care management records in accordance with social work documentation standards.
- Assists participants with money management as needed.
- Assists financial eligibility staff in resolving financial eligibility related issues for assigned caseload as needed.
- Attends conferences and seminars to maintain State Social Worker certification, and to stay informed of developing trends in geriatric social work practice.
- Develops knowledge of community networks and resources for elderly of diverse ethnic and cultural backgrounds, and forms collaborative relationships with same. Provides information to participants to assist in establishing and maintaining community links.
- Advocates on behalf of participants for benefits and services through government and community agencies.

- Assists participants in completing advance directives and guardianship paperwork.
- Provides bereavement follow-up as needed.
- Maintains client contact standards per Agency A policy.
- Facilitates participant enrollments and disenrollments from the program.
- Conducts home visits and home assessments as needed.
- Provides coverage for other social workers as needed.
- Participates in cross-site Social Work Department meetings, other site-based meetings, agency-wide committees, and provides cross-site in-services related to social services, including, but not limited to, annual Participant Rights in-services.
- Protects privacy and maintains confidentiality of employee, participant and sensitive agency information.
- Provides professional supervision to Human Service Workers on their team and/or at their site as needed.
- Performs related duties as assigned.

III. Qualifications and Requirements:

Education: Bachelor Degree in Social Work, and current State of Wisconsin Social Worker certification required. Master's Degree in Social Work or closely related field preferred.

Bachelor degree in a human services field, current State of Wisconsin Social Worker certification and a minimum of one year of experience providing social work case management services for the elderly may be substituted for the Bachelor degree in Social Work.

Experience: One to two years experience providing social work case management services to a frail or elderly population preferred.

Skills and Knowledge:

- Working knowledge of social service principles and practices.
- Knowledge of psychosocial, behavioral, and caregiving needs of the elderly population.
- Familiarity with illnesses common to the frail elderly population.
- Knowledge of normative, developmental processes of aging.
- Familiarity with psychosocial assessment tools.
- Effective interviewing skills.
- Ability to effectively facilitate team and family meetings.
- Ability to effectively prioritize and efficiently follow-through on responsibilities.
- Effective problem-solving skills.
- Effective verbal, listening and written communication skills.
- Familiarity with financing mechanisms such as Medicare, Medicaid, and SSI.
- Familiarity with _____ County health and social service delivery systems, and aging network.

- Proven ability to work in an interdisciplinary team.
- Basic computer skills.
- Demonstrates necessary skills and knowledge as outlined in attached position-specific Competency Assessment Profile.

Desired Personal Attributes:

- Empathetic.
- Ability to work sensitively and effectively with individuals of diverse ethnic and cultural backgrounds.
- Ability to work collaboratively and productively within an interdisciplinary team.
- Ability to maintain professional boundaries.
- Ability to maintain confidentiality
- Dependable, resourceful and flexible.

Other:

- Routine travel between sites and homes required.
- Must be able to work required schedule.

POSITION DESCRIPTION

POSITION TITLE:
Geriatric Social Worker

DEPARTMENT:
Partnership

REPORTS TO:
Partnership Program Manager

FLSA STATUS:
Exempt

POSITION SUMMARY:
Under supervision of the Partnership Program Manager, the Geriatric Social Worker position is responsible for assessing, delivering, coordinating, monitoring and evaluating the psychosocial services participants require to live as independently as possible in the community. The position provides a range of services which include mental health referrals and supportive counseling of participants and families, discharge planning, case management and related administrative duties. The Social Worker develops relationships with multiple external agencies related to the elderly including, but not limited to: _____ County Social Services, hospitals, coalitions for the elderly, Elder Law, home health care agencies, Alzheimer's Association, Skilled Nursing Facilities, Community-Based Residential Facilities (CBRF), Independent Living, etc.

JOB DUTIES AND RESPONSIBILITIES:

35% A. Supportive Counseling and Mental Health Referral Services:

1. Provide one-to-one participant supportive counseling/education services relating to such areas as grief, aging, elder abuse, finances, loss, disease process, and other issues as prescribed in the treatment plan.
2. Provide group education opportunities for participants as needed.
3. Provide assistance to participants regarding Advance Directives such as living wills, Health Care Power of Attorney, etc.
4. Ensure Advance Directives are reviewed and communicated on an every six-month basis.
5. Provide supportive counseling to family members.
6. Assist participants' family members and caregivers in their understanding of aging and their individual care situation.
7. Work with families on improving and/or maintaining a health living situation.
8. Provide and/or coordinate the provision of mental health referral services.
9. Provide and/or coordinate the provision of other referral services such as AODA, to best meet participant needs.
10. Liaison between the participant/family and other community service providers such as hospitals, skilled nursing facilities, CBRFs, elderly coalition programs, Social Security Office, etc.

35% B. Case Management

1. May screen for initial eligibility criteria for the program including age, residency and financial requirements.
2. Meet with potential participant/family/community case manager to provide verbal and written information about the program.
3. Complete psychological/social/economic assessments which may include: psychosocial history, Geriatric Depression Scale, Caregiver Questionnaire, Mini Mental State Exam.
4. Facilitate the determination of individual participant goals through an interdisciplinary team effort and interactions with participant and family.
5. Participate in interdisciplinary team meetings to provide psychosocial information and updates regarding participants.
6. Participate as a team member in the development of the Individual Service Plan (ISP), ensuring the ISP reflects the participant's life goals to maximize quality of life for that individual.
7. Present ISP to participants and their family, and if necessary, serving as a negotiator if points or service needs are to be changed.
8. Provide completed ISP to consumer, ensuring enrollment agreement is signed if needed.
9. Arrange for caregiver support services including respite.
10. Assess for need and locate and secure participant informal support, community-based and government resources when possible.
11. Participate with team, including participant, in reviewing and evaluating participant outcomes.
12. Provide on-site observations of participants and collaborate with staff so as to prevent and/or minimize acute episodes and emergencies from occurring.
13. Conduct regular participant visits, either in the home, day center, or other various settings, to determine, review and adjust services.
14. Communicate with participant's formal and informal support network as necessary, sharing information with interdisciplinary team.
15. Coordinate and assure the provision of various psychosocial services with the participant, such as transportation and housing.
16. Identify current or potential participant housing needs.
17. Assist in placement, monitoring adjustment period to new/on-going housing to address all psycho/social/economic needs and strengths.
18. Provide ongoing support through case management.
19. Be an advocate for participants and assist in obtaining necessary services.
20. Be responsible for overall participant financial management to ensure effective allocation of costs in a managed care environment.

15% C. Coordination of Discharge Planning:

Assist multidisciplinary team with discharge planning from hospital, skilled nursing facility, CBRF, etc.

10% D. Administrative Duties:

1. Participate in internal work groups, meetings and committees relative to position responsibilities.
2. Attend appropriate external meetings, groups, organizations and conferences to promote continuity of services and to promote personal professional development.
3. Accurately complete all necessary paperwork--enrollments, assessments, statistical records, medical records, and other documentation in the required time frames.
4. Participate in ongoing quality improvement activities.
5. Document participant-related activity into the information system as required.

5% **E. Other:**

1. Assist in program development such as developing an information system; peer support; forums for participants; performance indicators for providers; developing educational materials.
2. Provide information/assistance to Personal Care Workers (PCW) on areas related to human services.
3. Maintain current knowledge base and skills in social work practices, especially related to frail, elder population.
4. Participate in forwarding the mission and goals of the Partnership Program.
5. Participate in and take responsibility for own learning, seeking feedback on performance and actively participating in self and peer performance appraisal.
6. Provide back up coverage for other Social Work staff as necessary or assigned.
7. Demonstrate respect for participants.
8. Empower each participant to direct her/his own medical/psycho/social care as independently as possible.
9. Maintain participant confidentiality at all times.

POSITION QUALIFICATIONS:

- Master's degree in Social Work from a college or university accredited by the National Council of Social Work Education required.
- Experience in a medical/clinical setting or equivalent academic experience required. Minimum of two years experience in a social work setting with a geriatric population preferred.
- Knowledge of the human aging process as it relates to physical/psychological/social/spiritual well being required.
- Knowledge regarding issues of aging, mental health and AODA required.
- Knowledge of the continuum of the elderly services network required. Working knowledge base of family systems, group process, guardianship/protective services, power of attorney for finance/health, and elder abuse issues required.

- Knowledge and ability to execute a goal oriented care plan which addresses the following: management of physical/mental illness; reactions and adjustments to the aging process/illness/loss/role changes, etc.; assessments which maximize family support systems; stress management and coping strategies required.
- Knowledge of person-centered social work and an understanding of how it relates to quality of life issues required.
- Knowledge and experience in completing psychological/social/economic assessments required.
- Excellent organizational, negotiation, and decision-making skills required.
- Excellent oral and written communication skills required.
- Excellent customer service skills required.
- Basic key boarding skills required. Ability to enter data into Agency B computer system required.
- Ability to make appropriate referrals within this network to best meet client needs and strengths required.
- Ability to work well in a team environment. Prefer prior experience as a member of an interdisciplinary team providing social work interventions.
- Ability to effectively collaborate with a variety of staff, both internal and external required.
- Ability to function effectively in a fast paced and changing environment with multiple priorities and objectives required.
- Ability to effectively facilitate management of participants' financial resources required.
- Ability to work additional hours as necessary required.
- Ability to effect collaborative alliances and promote teamwork required.
- Ability to ensure a high level of customer satisfaction required.
- Ability to develop and maintain effective working relationships required.
- Ability to present a positive self and organizational image to outside parties required.
- Certification in the State of Wisconsin as a Social Worker (Temporary or CSW). Within nine months of hire or expiration of Temporary certification, required to be certified at level of Certified Advanced Practice Social Worker (CAPSW).
- Valid, State of Wisconsin driver's license in good standing (or the ability to obtain) and reliable transportation required.

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It is Agency B's policy to base hiring decisions solely on an individual's ability to perform essential job functions. Persons with disabilities are eligible for this position provided they can perform those functions with reasonable accommodation.

I have read and understand that the statements above are a description of the functions assigned my position.

_____

Employee Signature and Date

Agency A, Inc.

Position Description

NURSE PRACTIONER

I. Job Summary: Under the supervision of the Nurse Practitioner Supervisor provides primary health care to participants in the Agency A program, including assessment and development of the plan of care in collaboration with the interdisciplinary team, provision of direct patient care and evaluation of effectiveness of plan of care. The Nurse Practitioner functions in a collegial relationship with physicians and other health professionals making independent decisions about nursing needs and interdependent decisions with physicians regarding health regimens. Assumes dependent responsibilities in carrying out delegated medical acts. The quality of care is under the direction of the Chief Medical Officer.

II. Duties and Responsibilities:

Provides initial and ongoing participant assessment, care plan development and implement of plan in the clinic, group home, nursing home or home.

A. Assessment

- Obtains a complete health history and records findings.
- Performs physical examinations, functional status evaluations and/or mental status evaluations, orders and evaluates appropriate laboratory and diagnostic tests, and records findings.
- Identifies and describes behavioral patterns of the chronically ill associated with developmental processes, lifestyle, and family relationships.
- Identifies status changes in participants to facilitate appropriate management of problems.

B. Analysis, Decision Making

- Discriminates between normal and abnormal findings associated with aging, pathological processes, lifestyles, and/or family relationships as influenced by chronic illness.
- Exercises clinical judgment in differentiating between situations confounded by chronic illness, which the Nurse Practitioner can manage, and those which require consultations and/or referrals.
- Interprets screenings and selected diagnostic tests.

C. Managing, Planning, Treating, Evaluating

- Provides preventive health care, episodic care and health promotion for agency participants and arranges referrals as needed.
- Manages common self-limiting and/or episodic health problems according to protocol.

- Manages stabilized chronic illnesses in collaboration with physicians and/or according to protocol.
- In consultation with physicians, treats acute and chronic illness not covered by protocols.
- Regulates and adjusts medications as defined by protocol or current practice guidelines.
- Recommends symptomatic treatments and non-prescription medicines.
- Assists clients and families to assure greater responsibility for their own health maintenance and illness care by providing instruction, counseling, and guidance.
- Monitors participants in the hospital, nursing home and group home to provide continuity of care and assists in discharge planning.
- Evaluates the effectiveness of the participant's plan of care and revises as appropriate.
- Ability to utilize basic computer skills in the marketplace.

D. Other

- Functions as a member of the Interdisciplinary Team and participates in development of comprehensive plan of care and ongoing monitoring of participant's health status.
- Maintains current, accurate documentation of health care services, and prepares reports as required.
- Participates in participant-related conferences as designated.
- Protects privacy and maintains confidentiality of employee, participant and sensitive agency information.
- Serves on various committees of the organization as requested.
- Rotates as clinical administrator on-call for weekends and holidays.
- Performs related duties as assigned.

III. Qualifications and Requirements:

Education: Master's degree in nursing with completion of an accredited program for nurse practitioners (family, adult or geriatric) required. ANCC certification, current State of Wisconsin RN and Advanced Nurse Prescriber licenses required.

Experience: Minimum of one-year recent clinical nursing experience with a frail or elderly population required.

Skills and Knowledge:

- Knowledge of physical, mental and social needs of frail older adults.
- Strong clinical skills in physical assessment and chronic disease management for older adults.
- Ability to function independently within parameters of nurse practitioner/physician protocols in provision of preventive, chronic disease management and episodic health care for geriatric population.

- Effective organizational skills.
- Effective oral and written communication skills.
- Ability to coordinate services in various settings (i.e., day care centers, nursing homes, client's home, hospitals).
- Familiarity with and ability to utilize a computer.
- Demonstrates necessary skills and knowledge as outlined in attached position-specific Competency Assessment Profile.

Desired Person Attributes:

- Dependable, flexible and resourceful.
- Able to change priorities per participant needs.
- Interested in frail older adults.
- Ability to work effectively with physicians, staff of day care centers and other health providers.
- Ability to work sensitively and effectively with individuals of diverse ethnic and cultural backgrounds.

Other:

- Frequent travel between sites and homes required.
- Must be able to work required schedule.

POSITION DESCRIPTION

POSITION TITLE:
Nurse Practitioner

DEPARTMENT:
Partnership Program

REPORTS TO:
Partnership Program Manager

FLSA STATUS
Exempt

POSITION SUMMARY:
Under supervision of the Partnership Program Manager and the clinical direction and leadership of the Medical Director, the Nurse Practitioner position is responsible for collaborating with each participant's primary physician to provide advanced assessment, diagnosis and management of acute and chronic illness and primary health care to Partnership participants.

JOB DUTIES AND RESPONSIBILITIES:

60% A. Primary Health Care/Medical Management

1. Provide primary health care to Partnership participants, including those in group homes and nursing homes.
2. Focus on health maintenance, promotion of wellness, prevention and early intervention to assist the participant in maintaining functional and health status for as long as possible.
3. Provide diagnosis and management of acute and chronic illness.
4. Collaborate with internal resources, therapy and dietary to meet needs.
5. Collaborate with external resources such as dentists, podiatrists, audiologists, speech therapists and other agencies Agency B contracts with for participant care.
6. Determine the need for outside consultation and refer to other disciplines as necessary.
7. Provide periodic re-evaluation of medical status.
8. Conduct physical examinations for each participant upon enrollment, annually as indicated.
9. Provide initial history and physical exam.
10. Order, interpret and review laboratory results and diagnostics on an on-going basis.
11. Assess and prescribe medications, identifying and managing interactions.
12. Ensure immunizations are offered, provided and the information kept current in the database.
13. Order invasive nursing interventions, such as dressing changes, tube feedings, direct clinical monitoring of acute/chronic episodes.
14. Provide prevention and health maintenance education to participants at appropriate level and depth to augment their understanding.
15. Ensure health maintenance standards are offered and accessible.
16. Empower each participant to direct her/his own medical/psycho/social care as independently as possible.

17. Collaborate with family and/or care givers to ensure continuity of care.
18. Participate in interdisciplinary team meetings to provide health information and updates regarding participants.
19. Participate as team member in the development of the Plan of Care (POC), ensuring the POC reflects the participant's important issues and life goals in order to maximize quality of life for that individual.
20. Collaborate with the primary care physician to incorporate his/her suggestions into the Plan of Care.
21. Accompany patients to physician appointments, when appropriate, to enhance communication and serve as a liaison with the physician, participant and team.
22. Participate with the team, including the participant, in reviewing and evaluating participant outcomes.
23. Communicate with participant's formal and informal support network as necessary, sharing information with the interdisciplinary team.
24. Coordinate care with nursing homes, external agencies and other disciplines.
25. Communicate pertinent participant information to other health care providers as necessary in a professional and timely manner.

15% B. Case Management:

1. Collaborate with the team to coordinate resources and facilitate procurement of services to meet participant needs.
2. Provide inpatient case management by being the primary liaison with hospital staff in communicating member needs, identifying outcomes in collaboration with inpatient staff, and facilitating discharge planning with other team members as indicated per protocols.
3. In collaboration with primary care physician, authorize of specialty care, rehab, psychological services, evaluation or treatment.
4. Participate in utilization management activities as assigned.
5. Ensure program efficacy through cost analysis and resource utilization.
6. Assume leadership role in collaborating with appropriate providers prior to, during, and at discharge from inpatient settings, sub-acute care settings, and short-term skilled nursing homes, and nursing homes.
7. Serve as primary liaison between the team, the member, the Primary Care Physician.

10% C. Education/Outreach:

1. Provide education to participants and families to ensure informed decision-making regarding their health status and consequences of those decisions.
2. Serve as a clinical expert to the team by providing both formal and informal education and consultation to staff.
3. Provide participant/family education surrounding health maintenance, prevention, illness, medications and other relevant topics based on individual need.

4. Serve as a community educator and ambassador regarding the Partnership Program.
5. Provide information (written and verbal) to all external providers Partnership associates with for services.

5% **D. Quality Assurance/Improvement and Research:**

1. Participate in QA/I studies and agency activities, applying results to clinical programs.
2. Incorporate outcome based decision-making into practice based on QA/I results.
3. Support the planning of and participate in clinical research as approved by the Partnership Program.
4. Evaluate current research in geriatric nursing and apply to participant care within the Partnership Program.
5. Serve as a preceptor/mentor for graduate students involved in research projects.

10% **F. Other**

1. Attend appropriate external meetings, groups, organizations and conferences to promote continuity of services to promote personal professional development and to maintain professional practice requirements.
2. Accurately complete all necessary paperwork, such as enrollments, health assessments, statistical records, medical records, and other documentation in the required time frames.
3. Participate in ongoing quality improvement activities.
4. Assist in the development of systems of the Partnership Program.
5. Attend all required in-service training and meet all required health screening obligations.
6. Assist in program development such as development of an information system; per support; forums for participants; performance indicators for providers and development of educational materials.
7. Maintain current knowledge base, skills and awareness in community-based and geriatric nursing practice.
8. Participate in forwarding the mission and goals of the Partnership Program and Agency B.
9. Participate in and take responsibility for own learning, seeking feedback on performance and actively participating in self and peer performance appraisal.
10. Demonstrate respect for participants and staff.
11. Maintain a cooperative and supportive work relationship with participants, family and Agency B staff.
12. Maintain participant and staff confidentiality at all times.
13. Practice in a manner congruent with ANA Code of Ethics, Wisconsin Nursing Licensure Code, professional and Wisconsin Partnership Program.

14. Provide back up coverage for other nursing personnel as necessary or assigned.
15. Perform other duties as assigned.

POSITION QUALIFICATIONS:

- Master's degree in nursing required.
- Minimum of five years nursing experience preferred. Experience in a home care setting preferred. Prefer one year or more geriatric NP experience.
- Minimum of one year of geriatric experience preferred.
- Previous geriatric Nurse Practitioner experience preferred.
- Drug Enforcement Administration (DEA) registration (or eligibility for) required; current and valid DEA number for prescription purposes required.
- Expertise and ability to develop patient education materials as well as in providing education to individuals and groups required.
- Knowledge and skill in advanced physical assessment required.
- Knowledge of the human aging process and sufficient knowledge base regarding issues of geriatric nursing required.
- Good judgment, problem solving, and cognitive skills required.
- Effective leadership, organizational, negotiation, conflict resolution and decision-making skills required.
- Effective interpersonal communication skills required. Ability to work well in an interdisciplinary team environment required. Previous experience as a member of an interdisciplinary team providing nursing care preferred.
- Effective oral and written communication skills required.
- Basic key boarding skills required. Ability to enter data into Prime computer system required.
- Ability to function with a high degree of independence along with the ability to effectively collaborate with a variety of staff, both internal and external required.
- Ability to function effectively in a fast-paced and changing environment with multiple priorities and objectives required.
- Ability to work additional hours as necessary required.
- Effective human relations abilities required.
- Ability to effect collaborative alliances and promote teamwork required.
- Ability to insure a high level of participant satisfaction required.
- Ability to develop and maintain effective working relationships required.
- Ability to present a positive self and organizational image to outside parties required.
- Commitment to providing excellent customer service required.
- Valid, State of Wisconsin driver's license in good standing (or the ability to obtain), reliable transportation and auto insurance required.
- Licensure or eligibility for licensure in the State of Wisconsin as a Registered Nurse, Advance Practice Nurse Prescriber (APNP) licensure, and national NP certification in geriatrics, adult or family practice required.

individuals required to perform the job adequately. Duties, responsibilities and expectations may be added, deleted, or modified at any time at the discretion of agency B management.

It is Agency B's policy to base hiring decisions solely on an individual's ability to perform essential job functions. Persons with disabilities are eligible for this position provided they can perform those functions with reasonable accommodation.

I have read and understand that the statements above are a description of the functions assigned my position.

_____

Employee Signature and Date

Agency A, Inc.

Position Description

PERSONAL CARE WORKER - HOME CARE
and
CRISIS AIDE

I. Job Summary: Under the supervision of the Home Care Supervisor or Day Center Manager, and under the direction of the Home Care QI Coordinator about/or PCW QI Coordinator is responsible for providing various care services necessary for attending to the personal needs, support and health status of Agency A program participants primarily in the home environment.

II. Duties and Responsibilities:

- Provides in-home personal care and services which assist participants with activities of daily living, including toileting, showers, eating assistance, grooming and oral care. Assists participants in physical (e.g., exercise and walking) and recreational activities, and converses with participants.
- Provides homemaking services including preparing and serving meals and snacks according to specified nutritional needs and dietary restrictions as outlined on the plan of care. Performs light housekeeping tasks as outlined on plan of care including vacuuming, mopping, dusting, taking out trash, washing dishes, and doing laundry.
- Functions as a member of the interdisciplinary team reporting regularly on personal care services provided and the self-care abilities of participants, including changes in participants' condition. Makes suggestions to the Home Care QI Coordinator regarding changes in participant plans of care based on observed participant changes in condition and/or participants' expressed wishes.
- Keeps current on and follows individual participant care plans at all times.
- Adheres to Agency A safety requirements and participant care plans regarding use of assistive devices (e.g., gait belts, hoyer lifts, slide boards, etc.).
- Uses proper infection control and proper standard precautions at all times according to Agency A policy and procedure.
- Observes participants for emotional, behavior, and physical changes in condition including, but not limited to any changes in mood, skin integrity, bowel and bladder status, flood/fluid intake, speech, ambulation and transfer ability. Promptly reports participant change of condition to Agency A Systems Administrator/Home Care QI Coordinator or nursing staff.
- Provides support for clients, such as reminders to follow through with nursing instructions, taking medications ordered, and diet restrictions. Provides emotional reassurance as appropriate.
- Assists in identifying signs and symptoms indicating physical, emotional or behavioral change in clients, including, but not limited to, changes with skin,

bowel and bladder status, food/fluid intake, mood or transferring/ambulation skills. Promptly reports these indicators to the clinic staff and/or Home Care Manager.

- Maintains accurate and current written records indicating ongoing documentation of services provided, and participant's functioning.
- Follows appropriate medical emergency procedures according to Agency A policy and procedure and individual participant plan of care.
- Escorts clients for medical, dental, optometry, rehabilitation, and other appointments as necessary.
- Assures punctuality for participants' scheduled visits and van rides.
- Attends staff and participant care planning meetings and department and agency inservices as required.
- Provides personal care services in the ADHCs as caseload dictates. Collaborates with all other departments to ensure that the needs of participants are consistently met and that a clean, sanitary, and safe environment is maintained at all times. Assists with meal service and clean up of dining area(s) (tables and floor). Maintains order of personal care areas including but not limited to, coatroom, bath/shower rooms, personal care/linen supply areas, participant rooms, and laundry areas. Transports clients to clinic, recreation program areas (inside and outside of building), lobby area for drivers, etc. Attends to personal care needs of participants during recreation activities and assists participants with activities as needed. Assists participants with physical activity (e.g. walking for exercise). Does laundry as assigned.
- Adheres to all aspects of Agency A's Participant Rights Policy at all times.
- Immediately advises supervisory/management staff of any observed (seen or heard) mistreatment of participants or misappropriation of property. Immediately reports to supervisory or management staff any participant allegations of mistreatment or misappropriation.
- Protects privacy and maintains confidentiality of employee, participant and sensitive agency information.
- Performs related duties as assigned.
- Works rotating weekends and/or holidays as assigned.
- Performs related duties as assigned.

<u>Crisis Aide Duties and Responsibilities</u>: *(In addition to all of those above, the Crisis Aide is responsible for the duties and responsibilities below. The Crisis Aide duties and responsibilities apply only to those individuals who have been formally designated as Crisis Aides by their supervisor, and whose formal designation is documented in their personnel file.)*

- Carries pager/cell phone as part of regular work routine; keeps on at all times between required on-call hours, and responds promptly to pages/calls.
- Maintains regular contact (throughout each work day) with the Supervisor, supervisor designee, or Home Care Scheduler regarding daily assignment changes.

- Keeps pager/cell phone in working condition recharging as required. Immediately notifies supervisor of any pager/cell phone malfunction.
- Assists with orientation of new home care personal care workers and crisis aides as assigned.

III. Qualifications and Requirements:

Education: High school diploma or GED preferred. Current State of Wisconsin certification as a Home Health Aide or Nursing Assistant required.

Experience: One year experience caring for elderly or adult disabled persons as a nursing assistant in-home or, in a long-term care, group home or day care setting preferred. Experience working with dementia a plus. The Crisis Aide role requires one year of experience as a nursing assistant in a long term care setting and at least six months in-home experience.

Skills and Knowledge:

- Ability to relate effectively and sensitively to frail and cognitively impaired elderly individuals; ab9ility to establish a helping, trusting relationships with participants and their families.
- Ability to follow through with verbal and written directions and instructions accurately and in a timely manner with increasing independence; Ability to proceed on assignments independently.
- Ability to work collaboratively with all interdisciplinary team members as well as staff from support service departments.
- Knowledge of appropriate redirection techniques involved in relating to and caring for individuals with dementia.
- Ability to pro9perty and safely use assistive devices and personal care equipment (including oxygen equipment). Organized and able to prioritize.
- Demonstrates necessary skills and knowledge as outlined in attached position-specific Competency Assessment Profile.

Desired Personal Attributes:

- Dependable and flexible.
- Pleasant, patient, caring and respectful.
- Ability to adapt to changes, including accepting supervision or direction from designated management/supervisory/lead/QI staff, and adjust to changes in work assignment.
- Ability to work sensitively and effectively with individuals of diverse ethnic and cultural backgrounds.

Other:

- Requires physical strength to safely perform essential functions of the job.
- Routine travel between homes required.
- Must be able to work required schedule.